Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug, Please do so in the space provided and **FAX form back to the dispensing pharmacy**. Otherwise, continue with the Prior Authorization process by completing the rest of this form & FAX completed form to the Prior Authorization Unit @ 1-800-913-2229 (274-5956 Topeka)	**Rx** _____ Physician signature _____ Date

This includes all generic equivalents

ANTI-DIABETIC DRUGS - Biguanides			
Preferred Drug Covered	*This includes all generic equivalents*	**Non-preferred Prior Authorization Required**	*This includes all generic equivalents*
Metformin	Glucophage®	Metformin (Extended Release)	Glucophage XR® Fortamet®

** **Indicates REQUIRED information**

****CONSUMER NAME:** _____ ****Medicaid Number:**_____

****PHARMACY NAME:**_____ ****Medicaid Number:**_____

****Phone Number:**_____ ****Fax Number:**_____ ****NDC:**_____

****PRESCRIBING PHYSICIAN NAME:**_____ ****Medicaid Number:**_____

****Phone Number:**_____ ****Fax Number:**_____

** ***Indicate:*** Non-Preferred Drug prescribed: _____ Other:_____

** ***Check:*** the appropriate box indicating medical necessity for the Non-Preferred Drug and provide the requested information:

☐ Medical intolerance to Preferred Drug. **Provide clinical symptoms**:_____

_____

☐ Inadequate response to Preferred Drug.

** ***Indicate:*** Preferred Drug tried: _____ Length of trial: _____

☐ Absence of appropriate formulation or indication of the drug. Please specify:_____

_____

****Prescribing Physician's signature:** _____**Date:** _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593.

Revised 03/19/06